U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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Atlanta Regional Office

The Pulse of CMS

"A quarterly regional publication for health care professionals"
Serving Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi and Tennessee.

Dr. Mark McClellan Named Administrator of CMS

On March 11, the Senate confirmed President Bush's nomination of Dr. Mark B. McClellan as the new Administrator of the Centers for Medicare & Medicaid Services (CMS). Dr. McClellan, who was Commissioner of the Food and Drug Administration (FDA) before being named Tom Scully's successor, was also a member of the White House Council of Economic Advisors and a senior health policy aide to the President before moving to the FDA in 2002.

HHS Secretary Tommy Thompson issued the following statement:

"Mark McClellan will be an outstanding leader for the Centers for Medicare & Medicaid Services as the agency works to implement the new Medicare law and increase access to quality health care for American families. At FDA and throughout his career, Dr. McClellan has served the nation admirably while demonstrating exemplary leadership that will continue our efforts to build a strong and responsive CMS. His comprehensive understanding of the American health care system and dedication to public service make Dr. McClellan an ideal choice to lead CMS at this important time."

Inside this Issue...

Working to Improve Customer Service to Medicare Providers

CMS has embarked on a broad initiative to improve the quality of customer service provided by Medicare contractor call centers in 2004. Over 75 percent of all provider interactions occur with the provider call centers, so the importance of high quality customer service at the contractor call centers cannot be overstated. CMS has taken a number of steps to ensure that high quality service is delivered to all providers who call into the call centers.

First, we are working closely with call centers to develop effective measures of customer service satisfaction and to incorporate continuous quality improvement. In addition, routine inquiries such as claims status and eligibility are being referred to automated systems such as the Interactive Voice Response (IVR) system to free up Customer Service Representatives (CSRs) to handle the difficult and complex provider inquiries.

As far as other sources of Medicare information are concerned, CMS has remodeled the information contained at the Medlearn web site, which is now organized by provider specialty and contains Frequently Asked Questions that often address common issues that providers encounter. Finally, CMS is currently testing the viability of providers obtaining beneficiary eligibility and claims data via the Internet. Stay tuned for the results of this pilot project in the near future.

Higher Payment Rates for Medicare Health Plans Announced

CMS has announced increases in federal payment rates for Medicare Advantage health plans, aimed at supporting improvements in services and lower costs for Medicare beneficiaries enrolled in private health plans, as well as offering them more options for Medicare coverage.

The increased payments to Medicare Advantage, formerly known as Medicare+Choice, took effect March 1, and were included in the bipartisan Medicare Modernization Act of 2003 (MMA) recently signed into law by President Bush. The increases average 10.6 percent across plans.

The provision requires managed care organizations to use the funds to: 1) reduce beneficiary premiums or co-pays, 2) enhance benefits, 3) stabilize or expand the network of doctors and other health care providers available to seniors, or 4) offset either premium increases or reduced benefits in the future.

"These increases are an investment in our seniors. They are aimed at supporting better services for Medicare beneficiaries in health care plans. And at the same time they will help support more choice of Medicare options for all beneficiaries," HHS Secretary Tommy G. Thompson said. "We want private health plans to develop attractive benefits and strong networks of providers."

Quality Update: Latest on Hospital Reporting

Included in the Medicare Modernization Act of 2003 (MMA) is an important change to the National Voluntary Hospital Reporting Initiative (NVHRI). Section 501 of the MMA stipulates that hospitals that do not submit performance data for 10 quality measures will receive a 0.4 percent reduction in Medicare payments in fiscal year 2005 compared to hospitals that do report quality data.

In order to qualify for the full monetary update, hospitals must sign up with the Quality Improvement Organizations' (QIO) data warehouse by June 1, 2004 and transmit the required data there by July 1, 2004, which will reflect patient discharges during the most recent quarter available. Hospitals whose data submission has started but has not been completed by July 1 will be allowed a 30-day grace period to complete that data submission. This grace period applies to this initial year only.

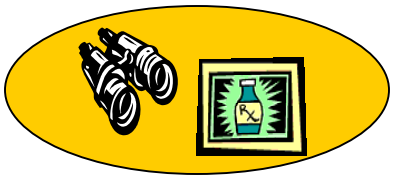
CMS is working closely with the American Hospital Association, the Federation of American Hospitals and others to ensure that hospitals are fully aware of these requirements. The QIOs, independent organizations working under contract to CMS, are available to provide technical assistance to hospitals in their data abstraction and submission. Hospitals are urged to contact their local QIO as soon as possible for this technical assistance. Visit http://www.cms.hhs.gov/quality/hospital for more information.

Focus on MMA: Drug Discount Card

The Medicare-Approved Prescription Drug Discount Card Program was enacted into law on December 8, 2003 as part of the Medicare Modernization Act of 2003 (MMA). This **voluntary program,** estimated to reduce the costs of prescription drugs between 10-15 percent for many seniors and disabled people covered under Medicare, is not intended to be a prescription drug benefit, but rather an interim step to help people receive discounts off the regular cash price of prescription drugs until the Medicare drug benefit takes effect on January 1, 2006. Drug cards approved by CMS will carry a Medicare-Approved seal on the card authenticating them and will be honored at participating pharmacies.

Enrollment begins in May 2004, and the card will be effective June 1, 2004 through December 31, 2005. Beneficiaries with Medicare Part A or B are eligible unless they are enrolled in Medicaid or covered through a Medicaid 1115 state waiver. An annual enrollment fee up to $30 (depending upon the plan) will be waived for beneficiaries with income below 135% of the Federal Poverty Level (FPL). For 2004, the FPL is $9,310 for single individuals or $12,490 for married individuals; in Alaska it is $11,630 for a single person and $15,610 for a couple (these income levels will vary slightly for subsequent years).

Beginning in June 2004, Medicare will provide $600 in 2004 and up to an additional $600 in 2005 to Medicare beneficiaries with incomes below 135 percent FPL. These funds will be



provided through the Medicare-Approved drug discount card. When applying the $600 toward prescription drug purchases, beneficiaries at or below 100 percent of poverty will pay 5 percent coinsurance. Beneficiaries between 100 and 135 percent of poverty will pay a 10 percent coinsurance. The credit is not available for persons with Medicaid, TRICARE, or an employer group health plan. There is no asset test for either the drug card or the $600 credit.

Drug card plans may offer formularies that must include one discounted drug in each of 209 classes commonly used by the elderly and may offer discounts on over-the-counter drugs that cannot be purchased with the $600 credit. Plans must offer web-based price comparisons and a grievance policy.

This interim benefit is on the fast track. Beneficiaries will be able to enroll in May 2004 with benefits effective June 1, 2004. CMS has reviewed applications from more than 100 potential drug card sponsors. CMS expects to announce the approved sponsors shortly.

You can find more information on the Medicare-Approved prescription drug discount card program at CMS' website.

Provider Outreach Staff:

David Hinson
Phone: (404) 562-7365

E-mail your questions and comments to us at: Atl_Provider Questions@cms.hhs.gov

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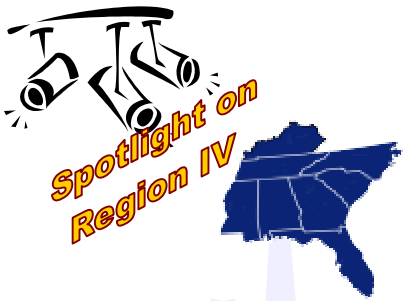

"The Pulse" will highlight data and facts pertaining to the states in Region IV. This quarter we feature Florida in the spotlight. Keep your eye out for more interesting fact from the other states in the region in upcoming issues!

Did you know...

FL spent $4,046 per capita on health care in 1998?

FL was the 8th largest state in health spending in the nation?

FL ranks 1st in percent of the population 65 and over, and ranks 4th in percent of the population 85 and over?

FL ranked 1st in percent of the population that are Medicare beneficiaries?

FAQ: Change in Reimbursement for Oncology Drugs

Q: What is the impact of the Medicare Modernization Act of 2003 (MMA) on reimbursement of chemotherapy drugs?

A: MMA reduced Medicare reimbursement for most chemotherapy drugs and some other drugs from 95% of the average wholesale price (AWP) to 85% of the AWP, in part to reflect more accurately the true acquisition cost of the drugs. Conversely, payments for the administration of such drugs were increased, in part by increasing the work component used in calculating the administration fee. CMS has estimated that the total annual reimbursement for the drugs would decrease by approximately $510 million in a single year. However, the reimbursement for the administration of the drugs would increase by a like amount, resulting in virtually no net change in total payments.

Stay Tuned...

In the Summer edition of "The Pulse of CMS," we will take a detailed look at the new Medicare Advantage program.

CMS & Its Medicare Contractors: What are the Distinctions?

Here at CMS, in our regular dealings with you, members of the community that provide care to our Medicare beneficiaries, we often get questions on how CMS works with its Medicare contractors- the carriers and fiscal intermediaries. Who is responsible for what?

CMS is a federal agency within the U.S. Department of Health and Human Services. This agency administers the Medicare program, Medicaid programs, and the State Children's Health Insurance Program (SCHIP) – three national health care programs that benefit over 80 million Americans. Our agency spends over $500 billion a year buying health care services for these three programs and:

- Assures that these three programs are properly run by our contractors and state agencies;
- Establishes policies for paying health care providers;
- Conducts research on the effectiveness of various methods of health care management, treatment and financing; and
- Assesses the quality of health care facilities and services and takes enforcement actions as appropriate.

With regard to the administration of the Medicare program, private insurance companies, under contract with CMS, handle payments to providers for hospital and medical services rendered to Medicare beneficiaries. These private insurance companies, also referred to as contractors, process claims for services covered under Medicare Part A (Hospital) and Medicare Part B (Medical) programs and are respectively known as fiscal intermediaries (FIs) and carriers. These Medicare contractors processed over one billion claims in FY 2003.

CMS has its Central Office in Baltimore, MD, and 10 Regional Offices across the country that are responsible for the general management and operational direction of all of the programs CMS oversees. Generally, the Central Office provides policy development and guidance while the Regional Offices manage the operational components across the country. Each Medicare contractor reports to a specific Regional Office. CMS monitors the contractors' day-to-day operations and, through a formalized process, evaluates the contractors' performance in several specific business functions on an ongoing basis. These oversight and evaluative practices are to assure that contractors are processing claims and other transactions correctly, operating efficiently and providing services to its customers.

Both CMS and its contractors are here to assist and support the provider, beneficiary and supplier communities. We strive to provide you with accurate, timely, and reliable information.

For specific information regarding Medicare contractors please visit the following web site at: http://www.cms.hhs.gov/contractors/

Click here to contact the individual contractors in your state.

HIPAA Privacy Reminder

Setting: Health Care Facility

Guess Who's Pregnant?

I know that a person named (---------) is two months pregnant and received specific medical services on 12/16/03 through a local lab. I know her date of birth, SSN, address, patient ID number, physician's name, and her account number. I know her diagnosis and whether her specimen was adequate for evaluation.

What is this information? It is PHI – Protected Health Information.

Do I need this information to do my job here at the physician's office? No. I do not know this person, and I am not working on anything related to her.

Why do I know this information? One page of a three-page lab report was left unattended in the fax machine this morning. Not only have I seen it, but also at least two others have seen it. They didn't need it to do their jobs either.

What's wrong with that? The HIPAA Privacy regulations required covered entities (i.e., most health plans,

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When Workers' Compensation Involves Medicare

Medicare is party to workers' compensation cases when the claimant is receiving or about to receive Medicare benefits. CMS is obligated to review these cases to ensure that a portion of the settlement is being appropriately obligated towards future medical treatment relevant to the work injury. As part of this review, medical documentation from any treating physician must be obtained and reviewed to determine current and future medical needs.

CMS needs your help in providing comprehensive medical documentation to patients who are in the process of resolving their workers' compensation claims. Securing appropriate documentation promptly will help expedite CMS review and allow claimants to fully settle their cases in a timely and efficient manner. For additional information regarding CMS review of workers' compensation cases, please visit the Workers' Compensation Bulletin.

Calendar of Events

April 4-7: Exhibit at the American Society of Professional Coders, Atlanta, GA

June 4-8: Exhibit at the American Diabetes Association, Orlando, FL

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HIPAA Privacy Reminder

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clearinghouses and healthcare providers) to implement standards to protect and guard against the misuse of PHI by the compliance date of 4/14/03. PHI is not to be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. The physician's office where I work has in place reasonable safeguards to limit the use or disclosure of PHI. However, in this instance, those procedures were not followed.

Please review your policies and procedures related to the HIPAA privacy provisions. The entity's Privacy Officer (every covered entity needs one) should periodically roam the office to validate that the procedures are being followed, and take necessary action when they are not.

For further information about HIPAA Privacy, please visit the Beneficiary Confidentiality Board.

Implementation of New Medicare Provider Enrollment System for Part B Providers

On November 3, 2003, CMS implemented the latest stage of the Provider Enrollment Chain and Ownership System (PECOS), CMS' new national provider enrollment system. PECOS has been used by Medicare's Part A fiscal intermediaries since July 2002 and is now being used by all Medicare Part B carriers. As of November 3, carriers were instructed to process any new enrollments and any changes in enrollment applications through PECOS. While some carriers have backlogs that must be reduced, other carriers have handled the transition to PECOS with less difficulty. There have been unanticipated CMS data center infrastructure issues that have caused system outages. These unanticipated outages have made PECOS inaccessible to carrier staffs for certain periods of time.

Another factor is the learning curve staff is experiencing at our carriers. This is a new, uniform business process, most times different from the way carriers processed provider enrollment applications in the past. Ongoing training and support has been provided by CMS but, as with any change of this magnitude, it is anticipated that slowdowns in work processing will occur for a time.

CMS recently assembled a senior leadership team with accountability for resolving these delays. This team is focusing on resolving delays in processing provider enrollment applications. CMS began conducting site visits to each Medicare carrier beginning in March. These teams will have direct responsibility to provide on-site focused customer service to individual carriers to resolve any issues related to PECOS and the provider enrollment business process so that delays in processing can be reduced or eliminated. Additionally, CMS working diligently to resolve CMS data system infrastructure issues that are causing outages in access to PECOS. The goal is to have the backlog inventories reduced by the summer of 2004.

Atlanta Regional Office:

Region IV
Division of Medicare Ops/PPR
Sam Nunn Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Phone: 404-562-7365
Fax: 404-562-7386
Email: dhinson@cms.hhs.gov